Infant's Medicaid ID #: _____
Mother's Medicaid ID #: _____ Date of Assessment:_____
Type: Open Card or Fee For Service_____ Managed Care (MHP):_____
Non-Medicaid: Location: ☐ Home Visit ☐ Other Visit
☐ Application in process. Explain_____ ☐ Office Visit
☐ Not yet applied. Explain _____

Has the consent form been signed? ☐YES ☐NO

Infant Support Services
INITIAL ASSESSMENT

GENERAL INFORMATION

Infant's First Name _____ Last Name _____ Date of Birth ____/_____/____ Race/Ethnicity _____
Mother's First Name _____ Last Name _____ Date of Birth ____/_____/____ Race/Ethnicity _____
Primary Caregiver's First Name _____ Last Name _____ Date of Birth ____/_____/____

Phone Number _____(hm) _____(wk) Best time to reach caregiver _____
Is there another phone number where you can be reached?_____
Current Address _____
Street Address City Zip County
Directions
_____
_____

Are you?
☐ Single ☐ Married
☐ Divorced ☐ Widowed
☐ Separated ☐ Cohabiting

Circle one: Mother or Primary Caregiver
Employment Status: ☐ Full Time (FT) ☐ Part Time (PT) ☐ Work First ☐ Not Working ☐ Student
Last Grade Completed _____ Race/Ethnicity _____
What language do you prefer to speak? _____
What language do you prefer to use for reading?_____

Name of Father of Baby (FOB)_____Date of Birth ____/_____/____ Race/Ethnicity_____
Employment Status: ☐ Full Time (FT) ☐ Part Time (PT) ☐ Not Working ☐ Student
Relationship with Mother: ☐ Involved ☐ Not Involved

Household Roster (List names of all members)*	Relationship to Infant	Sex	Race/Ethnicity	Age

*Include husband/partner if different than above; Mother of Baby (MOB) parents/FOB parents; MOB siblings/FOB siblings; MOB other children.

Infant's Name: _____

HEALTH INFORMATION

INFANT HEALTH

1. Gestational Age at Birth _____ Birth Weight _____ Birth Height _____ Head Circumference _____
2. Do you have a medical care provider that accepts Medicaid? ☐ YES ☐ NO
   If no, what kind of problem have you had in selecting a provider?_____
   _____
3. Have you had a well child visit with a medical care provider? ☐ YES ☐ NO
   a. Name of medical care provider_____
   b. Address/Location_____
   c. Infant's age of first appointment _____ Date of next appointment _____
4. Has your baby been admitted to the hospital since delivery? ☐ NO ☐ YES
   a. Intensive care ☐ NO ☐ YES
   b. Emergency room ☐ NO ☐ YES
   c. Pediatric Unit ☐ NO ☐ YES
   d. Name of Hospital _____
   e. Reason for admittance _____
5. Has your baby been diagnosed with special needs? ☐ NO ☐ YES
   a. Were there any positive test results from newborn screening? ☐ NO ☐ YES
   b. Is your baby enrolled in Children's Special Health Care Services? ☐ NO ☐ YES
6. Are you satisfied with the medical care your baby is receiving? ☐ YES ☐ NO
   If no, check all the items below that you are not satisfied with:
   - ☐ amount of time you had to wait to see the provider
   - ☐ amount of time the doctor or nurse spent with you during your visit
   - ☐ advice you received on how to take care of your baby
   - ☐ hours the office or clinic was open
   - ☐ understanding and respect the staff showed towards you as a person

MOTHER'S HEALTH *(Complete questions which have not been answered for Maternal Support Services Program)*

1. What month did you start prenatal care with this pregnancy? _____
2. How many prenatal visits were you able to keep for this pregnancy? _____
3. Have you had your six-week check-up (postpartum) after this pregnancy? ☐ YES ☐ NO
4. Previous Pregnancy:
   a. How many pregnancies have you had before this one?_____ How many living children?_____
   b. How many stillbirths (fetal deaths)?_____ miscarriages?_____ abortions?_____
   c. Have any of your children had a birth defect? ☐ NO ☐ YES
      If yes, please explain_____
      _____
   d. Did you have any complications with any previous pregnancy? ☐ NO ☐ YES
      If yes, please explain_____
      _____
5. Family Planning:
   a. Were you using birth control when you became pregnant with this child? ☐ YES ☐ NO
   b. What are you currently using for birth control?_____
   c. Do you need additional information on birth control methods? ☐ YES ☐ NO
6. Dental Health:
   a. Do you currently have a dentist? ☐ YES ☐ NO
   b. When was the last time you saw a dentist? _____
   c. Do you currently have any dental problems? ☐ NO ☐ YES
   d. Do your children have any dental problems? ☐ NO ☐ YES

SMOKING *(Complete questions which have not been answered for Maternal Support Services Program)*

1. Do you currently smoke cigarettes? ☐ NO ☐ YES
   a. How many cigarettes do you smoke a day? _____
   b. Have you cut down? ☐ YES ☐ NO
   c. Have you/are you seriously considering quitting? ☐ YES ☐ NO
2. Have you ever smoked? ☐ NO ☐ YES
   a. When did you stop smoking? _____
3. Do you plan to stay a non-smoker after this pregnancy ☐ YES ☐ NO
4. Has your smoking pattern changed since having the baby? ☐ NO ☐ YES
   If yes, please explain_____

Infant's Name: _____

IMMUNIZATIONS

1. Have you been immunized against any of the following infections?
   ☐ Chicken Pox ☐ Hepatitis B ☐ Measles ☐ Meningitis ☐ Mumps ☐ Rubella ☐ Don't Know
2. Have you ever been around anyone with these infections in the last month? ☐ NO ☐ YES
3. Are the immunization records on all preschool children in the household available? ☐ YES ☐ NO
4. What immunizations has your new baby received? _____
5. What questions do you have about immunizations? _____

INFANT'S NUTRITION

1. Infant current weight or at last doctor visit? _____ Current height/length? _____
2. Are you breastfeeding? ☐ YES ☐ NO
   If yes, what concerns do have about breast-feeding?_____
3. Are you bottle feeding? ☐ YES ☐ NO
   If yes, describe how you mix your formula?_____
   If yes, describe how you warm the bottle?_____
4. Do you put cereal in the bottle? ☐ NO ☐ YES
   If yes, how much? _____
   If yes, how often? _____
5. Is your baby eating solid food? ☐ YES ☐ NO
6. Describe a typical day's feeding: _____
   _____
7. How many of the following does your baby have per day?
   a. Bowel movement _____
   b. Wet diapers _____
8. How many times a day does your baby spit up? _____ When and how much?_____
9. What concerns do you have about the way your baby eats? _____
10. Do you have enough formula/food for a whole day? _____

MOTHER'S/ CAREGIVER'S NUTRITION

1. What changes, if any, have you made in your eating habits since the baby was born? _____
   _____
2. Have you ever had an eating disorder? ☐ NO ☐ YES
   If yes, please describe _____
3. Do you have enough food for yourself? ☐ YES ☐ NO
   a. For others in the household? ☐ YES ☐ NO
   b. Are you currently enrolled in WIC? ☐ YES ☐ NO
   c. Do you receive food stamps? ☐ YES ☐ NO
   d. What other resources do you have for food?_____

EMOTIONAL/ MENTAL HEALTH INFORMATION

EMOTIONAL/ MENTAL STRESS

1. Are you a first-time parent? ☐ NO ☐ YES
   If yes, have you taken care of a baby before? ☐ NO ☐ YES
   If no, what are your concerns about being a parent? _____
2. How did you feel when you found out you were pregnant? _____
3. How does your partner feel about this baby? _____
4. Is your partner the father of the baby? ☐ YES ☐ NO
   a. If no, what is your current relationship with the father of the baby? _____
   _____
5. Who can you depend on when you need help or someone to talk to? _____
   a. Will you be relying on them for assistance with child care? ☐ NO ☐ YES
   b. What agencies are helping you with the care of your baby? _____
6. Have you or a family member been involved with Children's Protective Services (CPS)? ☐ NO ☐ YES
7. Are you feeling particularly stressed right now? ☐ NO ☐ YES
   If yes, please describe. _____
8. How do you normally cope with stress? _____

Infant's Name: _____

9. What are you family strengths right now? _____
_____

10. Depression
    a. Have you had any of these feelings since your baby was born?
    ☐ Depressed mood ☐ Loss of interest in usually pleasurable activities ☐ Difficulty concentrating or making decisions
    ☐ Fatigue ☐ Changes in appetite or sleep ☐ Recurrent thoughts of suicide ☐ Feelings of worthlessness or guilt
    ☐ Excessive anxiety
    b. Have you ever been diagnosed with a mental illness by a health professional? ☐ NO ☐ YES
    If yes, are you currently taking medications for this illness? ☐ NO ☐ YES
    If yes, are you currently seeing a mental health counselor? ☐ NO ☐ YES

11. Domestic Violence – Since the baby was born:
    a. Has your partner pushed, hit, slapped, kicked, choked or physically hurt you in any way? ☐ NO ☐ YES
    b. Has anyone else physically hurt you in any way? ☐ NO ☐ YES
    c. Are you fearful of your safety at this time? ☐ NO ☐ YES

12. Parenting –
    a. Child Interaction Assessment (Complete this information from observation)
    ☐ Baby is easy to console
    ☐ Speaks endearingly to baby
    ☐ Has pleasurable time with feeding
    ☐ Seems confident about care giving
    ☐ Touches baby frequently
    ☐ Has eye contact with baby while holding
    ☐ Smiles at baby frequently
    ☐ Responds to baby's needs (in tune with baby)
    ☐ Prepared at home for baby
    ☐ Have realistic expectations of baby
    b. When your baby is upset, what do you do to quiet him or her? _____
    c. What questions do you have about taking care of your baby? _____

13. Growth and Development
    a. Which of these developmental milestones have you seen in your baby?
    ☐ Follows your face and eyes
    ☐ Sleeps for 3-4 hours at a time
    ☐ Good head control
    ☐ Rolls over
    ☐ Crawls
    ☐ Picks up with two fingers
    ☐ Recognizes your voice
    ☐ Coos or vocalizes
    ☐ Raises body on hands
    ☐ Shakes an object
    ☐ Walks
    ☐ Holds cup
    ☐ Lifts head when on stomach
    ☐ Smiles
    ☐ Sits with support
    ☐ Pulls to stand
    ☐ Plays peek-a-boo
    ☐ Feeds self

ENVIRONMENTAL INFORMATION

1. What is your current housing situation? (Select all that apply.)
    ☐ House-own ☐ Apartment ☐ Live with FOB ☐ Shelter ☐ Friend
    ☐ House-rent ☐ Live with SO (not fob) ☐ Migrant Housing ☐ Relative ☐ Rent
    ☐ Live with parents ☐ Homeless ☐ Other
2. Is your current housing?
    ☐ Built before 1950 ☐ Remodeled/renovated in the last year ☐ Near an industrial plant, dump site
3. Does your house (or frequently visited home) have peeling or chipping paint? ☐ NO ☐ YES
4. Does your house (or frequently visited home) have a lot of dust and mold? ☐ NO ☐ YES
5. Was asbestos insulation used on pipes or hot water tank or for insulation in attic/walls? ☐ NO ☐ YES
6. Does anyone in your household work around lead (pottery, automobile repair, plumbing)? ☐ NO ☐ YES

Infant's Name: _____

7. Do you regularly (at least weekly) use cleaners for glass, oven, floors, glues, solvents, paint strippers? ☐ NO ☐ YES
8. Do you currently use pesticides (bug or weed killer, flea or tick spray) in the home? ☐ NO ☐ YES
9. What is the source of your drinking water? ☐ well ☐ city ☐ store bought
10. Are the following in good working order? ☐ furnace ☐ plumbing ☐ refrigerator ☐ stove
11. Do you have a working smoke detector? ☐ YES ☐ NO
    Last time checked?_____
12. Does anyone in your household:
    a. Smoke? ☐ NO ☐ YES
    b. Use a wood stove? ☐ NO ☐ YES
13. Do you have guns and/or weapons in your home? ☐ NO ☐ YES
14. How many times have you moved in the past year? _____ Why? _____
15. Are you having any housing problems at this time? ☐ NO ☐ YES
    If yes, please describe _____
16. Are you having problems paying bills at this time? ☐ NO ☐ YES
    If yes, ☐ rent/mortgage ☐ gas ☐ electric ☐ phone
    More description _____
17. Do your child/children have a car seat? ☐ YES ☐ NO
    If yes, is the car seat ☐ new ☐ used
    a. Have you been shown how to install the seat in your vehicle? ☐ YES ☐ NO
18. Where does your new baby usually sleep?_____
    a. How do you most often lay your baby down to sleep? ☐ Back ☐ Side ☐ Stomach
    b. How often does your new baby sleep in the same bed with you or anyone else? _____
    c. Do you have a crib for your baby? ☐ YES ☐ NO
19. Do you need help getting baby items? ☐ YES ☐ NO

PARENTING EDUCATION CLASSES

1. Have you ever attended a group parenting class? ☐ NO ☐ YES
2. Would like to attend a group parenting class? ☐ YES ☐ NO
3. Will there be a problem getting to the class? ☐ NO ☐ YES

KEEPING MEDICAL APPOINTMENTS (TRANSPORTATION)

1. How do you usually get to healthcare appointments (e.g., doctor's office, WIC, lab, pharmacy, etc.)? _____
2. Do you drive? ☐ YES ☐ NO
3. Do you have access to a reliable vehicle? ☐ YES ☐ NO
4. Do you have any concerns with keeping your baby's medical appointments? _____
5. If you know, what is the maximum distance you will have to travel to keep your appointments? _____
6. If you are in a Medicaid Health Plan, have they ever helped you to get to the doctor's office? ☐ YES ☐ NO

SUMMARY

CAREGIVER'S SUMMARY

1. Do you understand what the ISS program is about? ☐ YES ☐ NO
2. What do you want the ISS team to work with you on? _____
   _____
3. Do you foresee any problems keeping appointments with the ISS team? ☐ NO ☐ YES
   What kind? _____
   _____

Infant's Name: _____

CLINICIAN ASSESSMENT SUMMARY

Strengths:

Weaknesses:

Referrals Made:

I have provided a copy of the following ISS program information:

- ☐ Caregiver grievance policy/procedure
- ☐ Medical and non-medical emergency options

ISS assessment form completed by:

Signature	Discipline	Date